2020-2021 Department of Labor Audit Checklist

Group Health Plan (GHP) Audits by the Department of Labor (DOL) verify and document compliance with federal statutory requirements. Expanded requests by the DOL include compliance with the Affordable Care Act (ACA), the Genetic Information Nondiscrimination Act (GINA) and revised stipulations for wellness incentive-based programs. New and revised regulatory guidance requires plan sponsors to take proactive recordkeeping steps to ensure compliance with the ongoing implementation process of the ACA. Enhanced enforcement also requires increased vigilance to prepare for a potential audit by the Employee Benefits Security Administration (EBSA) of the DOL. Oswald's audit checklist is intended as a guideline in coordination with Oswald's comprehensive compliance risk assessment tool and compliance checklist to ensure preparation for a DOL audit.

General Instructions

The items listed should be made available for review by DOL auditors, upon request. Unless otherwise specified, the period covered is from January 1, 2011 to the present. Photocopies should be provided for documents listed with an asterisk (*). When preparing documentation, please make two (2) copies: One for the Department of Labor and one for your records. **Note:** Additional documentation and photocopies may be requested as a result of the initial review**.**

General Requirements	Complete
The name , title, address and phone number for the Plan's contact person for all day- to- day Plan issues	☐
If the Plan is fully insured, please provide a copy of the most recent bill, premium request/invoice from the insurance carrier	☐
A copy of a cancelled check, wire transfer records or other method payment of premium	☐
Signed Plan Documents, Adoption Agreements, Trust Agreements, and Amendments to Date*	☐
Summary Plan Description*	☐
Signed Forms 5500, audited Plan Financial Statements all supplemental schedules from the last three years filed*	☐
Summary Annual Reports for the last three years*	☐
Minutes of any Plan or Committee meetings*	☐

Financial Requirements	
Trust Reports	☐
Bank and Brokerage Account Statements	☐
Documentation of all premium payments made to carriers	☐
401 K Account Ledgers/Journals (Receipts and Disbursements of Plan Assets, Documentation of claim payments)	☐
Invoices/Records relating to Expenses and /or Feed paid from Plan Assets	☐
Checkbook registry, canceled checks and deposit slips	☐

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Service Provider Requirements	
Service Providers Contracts or Letters of Engagement (Investment Manager Agreements, Third Party Administrator Contracts, Attorneys and Accountants)*	☐
Latest Fiduciary Liability Insurance Policy (if applicable)*	☐
Latest Fidelity Bond Policy, including all Riders and Endorsements, covering fraud and dishonesty*	☐
Listing of all officers of the Plan Sponsor and their tenure*	☐
Listing of all Plan Trustees and/or Fiduciaries and their tenure *	☐

Health Insurance Requirements	
All health insurance contracts and policies including all amendments and riders covering the Plan since January 1, __________*	☐
If self-insured all contracts for claims processing, administrative services and reinsurance*	☐
Documents which describe the responsibilities of both the employer and employees with respect to the payment of the costs associated with the purchase and maintenance of health and welfare benefits.	☐
A copy of an employee enrollment application in use*	☐
Plan and issuer compensation agreements with attending providers for hospital stays in connection with childbirth and reconstructive surgery in connection with a mastectomy*	☐
Required Notices: A copy of the following required notices including lists and logs of issued notices and a description of procedures for distribution*	
a. Notice of special enrollment rights, including lists or logs the Plan Administrator maintains related to the issuance of the notice.	☐
b. Enrollment and annual notices required under the Women's Health and Cancer Rights Act	☐
c. Newborn's Act notice relating to hospital stays in connection with childbirth	☐
d. Notice regarding premium assistance under Medicaid or CHIP	☐
e. Michelle's Law notice	☐
Required HIPAA Compliance: To ensure compliance with the HIPAA nondiscrimination rules that prohibit discrimination in the individual premiums based on a health factor (including list bill) the following items may be reviewed	
a. Health insurance billing invoices	☐
b. Premium schedules	☐
c. Employee and Employer contribution schedules	☐
d. And/or payroll records of withholding for benefits	☐
A sample of the Certificate of Creditable Coverage provided to those employees who have lost health care coverage since January 1, __________ or to be provided to those who may lose health care coverage under this plan in the future, which certifies creditable coverage earned under this plan*	☐
A copy of the record log of all Certificates of Creditable Coverage for individuals who lost coverage under the plan or requested certificates*	☐
A copy of written procedure for individuals to request and receive certificates*	☐
A sample general notice preexisting condition informing individuals of the exclusion period, the terms of the exclusion period, and the right of the individuals to demonstrate creditable coverage (and any applicable waiting or affiliation periods) to reduce the preexisting condition exclusion period, or proof that the plan does not impose a preexisting condition exclusion*	☐
A sample COBRA Notice for the plan	☐
A copy of the written appeal procedures established by the Plan	☐
A copy of the necessary criteria for an individual without a certificate of creditable coverage to demonstrate creditable coverage by alternative means*	☐

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Records of claims denied due to imposition of the preexisting condition exclusion (as well as the Plan's determination and reconsideration of creditable coverage, if applicable) or proof that the Plan does not impose a preexisting condition exclusion*	☐
Materials describing the Plan's procedures regarding the participants of the length of preexisting condition exclusion period that remains after offsetting for prior creditable coverage (if not completely offset)*	☐
A copy of the Plan's rules regarding coverage of medical/surgical and mental health benefits, including information as to any aggregate lifetime dollar limits and annual dollar limits	☐
Materials describing any wellness programs or disease management programs offered. If the program offers a reward based on individuals ability to meet a standard relief to a health factor, the plan should also include its wellness program disclosure statement regarding the availability of a reasonable alternative*	☐

ACA Grandfathered or Non-Grandfathered Status Requirements

If the Plan is claiming or has claimed grandfathered health plan status within the meaning of section 1251 of the Affordable Care Act, provide the following records	
a. A copy of the grandfathered health plan status disclosure statement that was required to be included in plan materials provided to participants and beneficiaries describing the benefits provided under the Plan*	☐
b. Records documenting the terms of the Plan in effect on March 23, 2010 and any other documents necessary to verify, explain or clarify status as a grandfathered health plan. This may include documentation relating to the terms of cost sharing(fixed and fixed percentages), the contribution rate of the employer or employee organization towards the cost of any tier of coverage, annual and lifetime limits on benefits, and if applicable, any contract with a health insurance issuer, which were in effect on March 23, 2010*	☐
Regardless of whether the Plan is claiming grandfathered status, please provide the following records in accordance with section 715 of ERISA as added by the Affordable Care Act	
a. In a case of a plan that provides dependent coverage, a sample of the written notice describing enrollment opportunities relating to dependent coverage of children age 26*	☐
b. If the Plan has rescinded any participants or beneficiaries coverage, a list of participants or beneficiaries whose coverage has been rescinded, the reason for the rescission, and a copy of the written notice of rescission that was proved 30 days in advance of any rescission of coverage*	☐
c. If the Plan imposes a lifetime limit or has imposed a lifetime limit at any point since September 23, 2010 provide documents showing the limits applicable for each plan year on or after September 23, 2010*	☐
d. Please provide a sample of any notice sent to participants or beneficiaries stating that the lifetime limit on the dollar value of all benefits no longer applies and that the individual, if covered, is once again eligible for benefits under the plan*	☐
e. If the Plan imposes an annual limit or has imposed an annual limit at any point since September 23, 2010, please provide documents showing the limits applicable for each plan year on or after September 23, 2010	☐
If the Plan is **NOT** claiming grandfathered health plan status under section 1251 of the Affordable Care Act provide the following records	
a. A Copy of the choice of provider notice informing participants of the right to designate any participating primary care provider, physician specializing in pediatrics in the case of a child, or health care professional specializing in obstetric or gynecology in the case of women, and list of participants who received the disclosure notice.	☐
b. If the Plan provides any benefits with respect to emergency services in an emergency department of a hospital, provide copies of documents relating to such emergency services for each plan year on or after September 23, 2010	☐

c. Copies of documents relating to the provision of preventative services for each plan year on or after September 23, 2010	☐
d. Copy of Plan's Internal Claim and Appeals and External Review Process	☐
e. Copies of a notice of adverse benefit determination, notice of final internal adverse determination notice , and notice of final external review decision	☐
f. If applicable, any contract or agreement with any independent review organization or third party administrator providing external review	☐
Notices provided to participants and beneficiaries explaining their rights to contribution of coverage as required by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), including a list or logs of notices issued*	☐
All documents relating to the use or collection of genetic information, for any reason, with respect to the Plan	☐
For Plan years or open enrollment periods beginning on or after September 23, 2012, a copy of the Summary of Benefits and Coverage and uniform Glossary provided to participants (if applicable)	☐
Any other documents which may explain or clarify the above items.	☐